U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 17 January 2006

In the Matter of:

CLARENCE HARLESS,
Claimant

v.

WOLF CREEK COLLIERIES,
d/b/a SMC,
Employer

and

Zeigler Coal Holding Co.,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-Interest

Case No. 2003-BLA-5438

Appearances:

Michael T. Hogan, Esquire
Louisa, Kentucky 41230
For Claimant

Lois A. Kitts, Esquire[1]
Baird and Baird, PSC
Pikeville, Kentucky 41502
For Employer

Before: Alice M. Craft
Administrative Law Judge

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[1]By Order dated January 11, 2005, I granted Baird and Baird's request to withdraw as attorneys of record due to the responsible operator's bankruptcy. By status report dated March 14, 2005, the Director, Office of Workers' Compensation Programs, reported that there is a surety bond issued by Frontier Insurance Company which may cover an award of benefits. The Director therefore requested that Wolf Creek Collieries be retained as the responsible operator. By Order dated April 28, 2005, I granted the Director's request to proceed to adjudication.

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. The Act and implementing regulations, 20 C.F.R. Parts 410, 718, 725 and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 C.F.R. § 718.201 (2005). In this case, Clarence Harless, Claimant, alleges that he is totally disabled by coal workers' pneumoconiosis.

I conducted a hearing on this claim on May 18, 2004, in Prestonsburg, Kentucky. Both parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 C.F.R. Part 18 (2005). At the hearing, Claimant was the only witness. Transcript ("Tr.") at 16–26. Director's Exhibits ("DX") 1–36, Claimant's Exhibits ("CX") 1–2 and Employer's Exhibits ("EX") 1–10 were admitted into evidence without objection. Tr. at 8, 11, 14. The record was held open after the hearing to allow the parties to submit additional evidence and argument. Dr. Rosenberg's deposition transcript was received post-hearing as was the addendum to his written report. These are now identified as EX 11 and EX 12, respectively, and are admitted into evidence. Dr. Jerome Wiot's September 14, 2004 report of his interpretations of various CT scans (6/9/03; 10/10/03; 1/14/04; and 5/6/04) is now identified as EX 13 and is admitted into evidence. Finally, Dr. Wiot's September 14, 2004 report regarding chest x-rays from March 26, 2003 and August 13, 2003 is now identified as EX 14 and is admitted into the record.[2] Employer filed a post-hearing brief on December 1, 2004. The record is now closed.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence, the testimony at hearing, and the arguments of the parties.

PROCEDURAL HISTORY

Claimant filed his initial claim on November 13, 1997. DX 1. The claim was denied by the District Director of the Office of Workers' Compensation Programs ("OWCP") on April 17, 1998, on the grounds that the evidence did not show that Claimant had pneumoconiosis, or that it was caused by coal mine work, or that Claimant was totally disabled. Claimant did not appeal that determination. DX 1.

More than one year later, Claimant filed a subsequent claim on February 7, 2001. DX 2. The Director issued a proposed Decision and Order denying benefits on October 16, 2002. DX

[2]Employer also submitted Dr. Wiot's interpretation of two different chest x-rays dated March 5, 1996 and January 9, 1998, respectively. I have not considered this evidence that predates the denial of Claimant's initial claim on April 17, 1998. Evidence in existence before the denial of the previous claim need not be considered in determining whether there has been a change in conditions. *See Cline v. Westmoreland Coal Co.*, 21 B.L.R. 1-69, 1-74 (1997).

26. The District Director found the presence of coal workers' pneumoconiosis, but did not find evidence of a total respiratory disability attributable to coal workers' pneumoconiosis. DX 26. Claimant appealed that determination in a letter dated November 7, 2002. DX 28. In a letter dated October 22, 2002, Employer objected to the findings of disease and causation. DX 27. The claim was referred to the Office of Administrative Law Judges for hearing on February 11, 2003. DX 34.

APPLICABLE STANDARDS

This claim relates to a "subsequent" claim filed on February 7, 2001. Because the claim at issue was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations, the current regulations at 20 C.F.R. Parts 718 and 725 apply. 20 C.F.R. §§ 718.2 and 725.2 (2005). Pursuant to 20 C.F.R. § 725.309(d) (2005), in order to establish that he is entitled to benefits, Claimant must demonstrate that "one of the applicable conditions of entitlement … has changed since the date upon which the order denying the prior claim became final" such that he now meets the requirements for entitlement to benefits under 20 C.F.R. Part 718. In order to establish entitlement to benefits under Part 718, Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 C.F.R. §§ 718.1, 718.202, 718.203 and 718.204 (2005). I must consider the new evidence and determine whether Claimant has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he is entitled to benefits. *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994).

ISSUES

At the hearing, the parties stipulated that Claimant has established at least twenty years of coal mine employment and that his wife, Helen, is his only dependent for purposes of augmentation of benefits. Tr. at 6, 21. The issues contested by the Employer and the Director are as follows:

1. Whether Claimant has pneumoconiosis as defined by the Act and the regulations;

2. Whether his pneumoconiosis arose out of coal mine employment;

3. Whether he is totally disabled;

4. Whether his disability was due to pneumoconiosis; and

5. Whether the evidence establishes that one of the applicable conditions of entitlement has changed pursuant to 20 C.F.R. § 725.309 (2005).

DX 34; Tr. at 5–6. The Employer also reserves its right to challenge the statute and regulations. DX-34; Tr. at 6.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and Claimant's Testimony

Claimant testified that he worked for over 24 years at Wolf Creek Collieries and was engaged in underground coal mining. He was a scoop operator, a miner operator, and a pinner and supply operator. Tr. at 17. Claimant described that he worked around asbestos and smoke from burning grease and smoke from batteries in the scoop he operated. Tr. at 23–24. He stated that his last coal mine employment was in Kentucky. DX 3. Therefore this claim is governed by the law of the Sixth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc). Since 1996, Claimant has not worked in any capacity. Tr. at 18.

Claimant married his wife, Helen, in 1970, and they remain married. DX 2, 9; Tr. at 21. He stated that he stopped smoking in October 2001. Tr. at 25. Prior to 2001, he smoked about ½ pack of cigarettes a day, but he reported that when he was doing 16–18 hour shifts a day in the mines, he would have only 2–3 cigarettes a day. Tr. at 18. In regard to his lung condition, he reported that he is "a lot weaker" and that he has "no energy to do nothing." Tr. at 19. He also testified that his condition "seems like it's getting worse" since the time of his previous application for benefits. Tr. at 23. Claimant uses an Albuterol inhaler during the day and a CPAP machine at night for sleep apnea. Tr. at 20–24. He has been treated by Dr. Sanchez for about three years. Tr. at 25.

Change in Conditions

In a subsequent claim, the threshold issue is whether one of the applicable conditions of entitlement has changed since the previous claim was denied. The first determination must be whether Claimant has established with new evidence that he suffers from pneumoconiosis or other pulmonary or respiratory impairment significantly related to or aggravated by dust exposure. Absent a finding that he suffers from such impairment, none of the elements previously decided against him can be established, and his claim must fail, because a living miner cannot be entitled to black lung benefits unless he is totally disabled based on pulmonary or respiratory impairments. Nonrespiratory and nonpulmonary impairments are irrelevant to establishing total disability for the purpose of entitlement to black lung benefits. 20 C.F.R. § 718.204(a) (2005); *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (4th Cir. 1994); *Beatty v. Danri Corp*., 16 B.L.R. 1-11, 1-15 (1991), *aff'd*. 49 F.3d 993 (3d Cir. 1995). As will be discussed in detail below, the medical evidence filed in connection with his current claim does not establish that Claimant has pneumoconiosis or any other pulmonary or respiratory impairment which is totally disabling. Thus he has not established a change in one of the applicable conditions of entitlement. It follows that I do not need to address the evidence in the record from his previous claims in explaining my decision that he is not entitled to benefits.

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in connection with the current claim.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b) (2005). Any such readings are therefore included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH), and/or the registry of physicians' specialties maintained by the American Board of Medical Specialties.[3] If no qualifications are noted for any of the following physicians, it means that either they have no special qualifications for reading x-rays, or I have been unable to ascertain their qualifications from the record, the NIOSH lists, or the Board of Medical Specialties. Qualifications of physicians are abbreviated as follows: A = NIOSH certified A reader; B = NIOSH certified B reader; BCR = board-certified in radiology. Readers who are board-certified radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n.16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

[3]NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, List of NIOSH Approved B Readers with Inclusive Dates of Approval [as of] June 7, 2004, found at http://www.oalj.dol.gov/public/blalung/refrnc/bread3_07_04.htm. Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www.cdc.gov/niosh/topics/chestradiography/breader-list.html. Information about physician board certifications appears on the web-site of the American Board of Medical Specialties, found at http://www.abms.org.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
05/11/01	DX 11 Tweel, B 1/1	DX 25; EX 1 Wiot/BCR, B No evidence of CWP	DX 12 Sargent/BCR, B Quality "1"
01/17/03		EX 2 Rosenberg/BCR, B EX 6, 7 Halbert/BCR, B No CWP	
03/26/03			CX 1, 2 Yama EX 14 Wiot/BCR, B Film totally unacceptable for evaluation by ILO standards.
08/13/03			EX 14 Wiot/BCR, B Film totally unacceptable by ILO standards.

Biopsies

Biopsies may be the basis for a finding of the existence of pneumoconiosis. A finding of anthracotic pigmentation is not sufficient, by itself, to establish pneumoconiosis. 20 C.F.R. § 718.202(a)(2) (2005). Section 718.106(a) provides that a biopsy report shall include a detailed gross macroscopic and microscopic description of the lungs or visualized portion of a lung. If a surgical procedure was performed to obtain a portion of a lung, the evidence should include a copy of the surgical note and the pathology report. The Benefits Review Board has held, however, that the quality standards are not mandatory and failure to comply with the standards goes only to the reliability and weight of the evidence. *Dillon v. Peabody Coal Co*., 11 B.L.R. 1-113, 1-114 (1988); *see Dagnan v. Black Diamond Coal Mining Co*., 994 F.2d 1536, 1540-1541 (11th Cir. 1992). Section 718.106(c) provides that "[a] negative biopsy is not conclusive evidence that the miner does not have pneumoconiosis. However, where positive findings are obtained on biopsy, the results will constitute evidence of the presence of pneumoconiosis."

There is one biopsy report in evidence in this case. In March 2003, Claimant was admitted to King's Daughter Medical Center because of a mediastinal adenopathy and right lung lesion. A biopsy was performed on March 26, 2003. CX 1. The tissue submitted for analysis was the right paratracheal lymph nodes. The gross description noted that some of the specimen

fragments were "nodular in configuration" and that "[t]hey range from 4 mm. up to 1.5 cm. in greatest diameter." The microscopic description was as follows:

> The frozen section diagnosis is confirmed. Sections demonstrate multiple pieces of lymph node tissue containing innumerable non-caseating histiocytic granulomas. Many of the granulomas also contain multinucleated giant cells, some of which display the presence of asteroid bodies. In the light of this finding, and the appearance of the granulomas, they most likely represent sarcoidosis.

The final diagnosis was as follows:

> Right paratracheal lymph nodes, biopsy: non-caseating histiocytic granulomas morphologically most suggestive of sarcoidosis (see micro).

CX 1.

CT Scans

CT scans may be used to diagnose pneumoconiosis and other pulmonary diseases. The regulations provide no guidance for the evaluation of CT scans. They are not subject to the specific requirements for evaluation of x-rays, and must be weighed with other acceptable medical evidence. *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-33-1-34 (1991). The record in this case contains reports of six CT scans of Claimant's chest.

Exhibit #	Date of CT	Reading Physician	Interpretation or Impression
EX 9, 10	01/17/03	Wiot/BCR, B	No evidence of coal workers' pneumoconiosis. Granulomatous disease; mild emphysematous change.
EX 6, 7		Halbert/BCR, B	No evidence of pneumoconiosis.
EX 5, 8	02/19/03	Poulos/BCR, B	No evidence of pneumoconiosis.
CX 1		Dransfeld	Mediastinal and hilar lymphadenopathy
EX 13	06/09/03	Wiot/BCR, B	No evidence of pneumoconiosis; findings consistent with sarcoidosis.
CX 1		Alapati	Superior and anterior mediastinal adenopathy; a 2 mm nodular density within the periphery of the right middle lobe, could represent nonspecific nodule, follow-up recommended to assess the stability of this lesion.
EX 13	10/10/03	Wiot/BCR, B	No evidence of coal workers' pneumoconiosis; evidence of mediastinal and hilar adenopathy.

Exhibit #	Date of CT	Reading Physician	Interpretation or Impression
EX 13	01/14/04	Wiot/BCR, B	No evidence of coal workers' pneumoconiosis; improvement of adenopathy.
EX 13	05/06/04	Wiot/BCR, B	No evidence of coal workers' pneumoconiosis; previously noted adenopathy essentially resolved.

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. In a pulmonary function study, the greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in connection with the current claim. "Pre" and "post" refer to administration of bronchodilators. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 C.F.R. § 718.204(b)(2)(i) (2005).

Ex. No. Date Physician	Age Height[4]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 11 05/11/01 Tweel	52 68.5"	2.64 2.54	5.04 4.95	52 51	76 80	No No	Mild obstructive ventilatory impairment without a response to bronchodilator. Efforts inconsistent.
EX 1 01/17/03 Rosenberg	54 67"	2.55 2.63	3.42 3.51	89 90	78 103	No No	Good cooperation and effort.
CX 1 02/27/03 Sanchez	54 67"	2.68 2.82	3.67 3.81	72 74	— —	No No	Good patient effort

[4]The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). None of the tests are qualifying to show disability whether considering the average height, or the heights listed by the persons who administered the testing.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (pO_2) and the percentage of carbon dioxide (pCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in connection with the current claim. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b) (2005).

Exhibit Number	Date	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify?	Physician Impression
DX 11	05/11/01	Tweel	46	78	No	—
EX 1	01/17/03	Rosenberg	42.5	68.4	No	—
CX 1	02/27/03	Sanchez	43	72	No	—

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 C.F.R. §§ 718.202(a)(4) (2005). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 C.F.R. § 718.202(a)(4) (2005). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 C.F.R. § 718.204(b)(2)(iv) (2005). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 C.F.R. § 718.204(c)(2) (2005). The record contains the following medical opinions submitted in connection with the current claim.

Dr. Harry Tweel examined Claimant on behalf of the Department of Labor on May 11, 2001. DX 11. Dr. Tweel is board-certified in internal medicine and pulmonary disease, and a B reader. He took occupational, social, family, and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He reported that Claimant worked in the mines for approximately 25 years. He reported that Claimant is a smoker with a history of 35 years, but in that time, there were at least 12 years where Claimant smoked only 3 cigarettes a day. The chest examination revealed no wheezes, rales, or rhonchi. Dr. Tweel read the x-ray as showing pneumoconiosis 1/1, asbestosis, and emphysema. The pulmonary function test showed mild obstructive ventilatory impairment without response to bronchodilator. He also noted, however, that "patient's efforts were inconsistent and do not meet ATS criteria for accurate interpretation." Dr. Tweel diagnosed possible asbestosis, minimal evidence of coal workers' pneumoconiosis, and evidence of mild smoker's bronchitis. Dr. Tweel gave no opinion regarding whether Claimant had a total respiratory disability. DX 11.

Dr. David M. Rosenberg examined Claimant on January 17, 2003 on behalf of Employer. EX 1. Dr. Rosenberg is board-certified in internal medicine and pulmonary disease. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He reported that Claimant smoked for approximately 34 years, smoking ½ pack of cigarettes a day continuing up to two months prior to examination by Dr. Rosenberg. Dr. Rosenberg noted that Claimant's "cotinine and nicotine levels were significantly increased (220mg/ml and 21ng/ml respectively), consistent with levels seen in an [sic] habitual smoker." Dr. Rosenberg reported that Claimant was in no distress at the office visit and that his lung examination revealed no rales, rhonchi, or wheezes and that he had equal expansion of his chest. The pulmonary function studies indicated "no significant obstruction or restriction," no impairments, and did not reveal COPD. The chest x-ray was negative for pneumoconiosis. Dr. Rosenberg concluded:

> It can be stated with a reasonable degree of medical certainty, [that Claimant] does not have CWP or associated impairment. He obviously is overweight, has diabetes, and PVCs were noted on his EKG, with a question of cardiomegaly.

EX 1. Dr. Rosenberg opined that Claimant could have a "lymphoma or some other malignancy." EX 1.

In a deposition taken on May 10, 2004, Dr. David M. Rosenberg essentially reiterated his written findings and conclusions. EX 11. He reiterated his conclusion that Claimant did not present evidence of medical or legal pneumoconiosis. EX 11, p.10. He described that Claimant's reduced pO2 was due to excessive weight. EX 11, p.11. Dr. Rosenberg testified in detail about the differences in patients with COPD due to cigarette smoking and patients with COPD due to coal mine dust exposure. He stated that "coal-mine dusts can cause a degree of decrease in the FEV1, reduction in the airflow; but the way in which that's manifested clinically is different than smoking-related obstructive lung disease." EX 11, p.16. In addition he stated:

> [i]n cigarette-smoking COPD, one sees a decrease in FEV1 percent or with air trapping, increase of the volume, oftentimes with an increased total lung capacity. These are the

kinds of parameters that are not found in obstructive lung [disease] from coal-mine-dust exposure.

EX 11, p.17. Dr. Rosenberg concluded that Claimant retained the respiratory capacity to perform his previous coal mine employment and that he had no respiratory impairment due to coal mine dust exposure. EX 11, p.18.

In an addendum dated September 14, 2004, Dr. Rosenberg reviewed additional medical records (specifically the King's Daughter Medical Center records and the Three Rivers Medical Center records) and reiterated his conclusion that Claimant does not have coal workers' pneumoconiosis or a total respiratory impairment. He concluded that Claimant had sarcoidosis, which "does not represent medical or legal CWP" and is unrelated to inhalation of coal mine dust. EX 12.

Dr. Peter Tuteur reviewed Claimant's medical records and provided a report dated June 9, 2003. EX 3. Dr. Tuteur is a board-certified pulmonologist. EX 4. He reviewed records dating back to 1995. He described that Claimant worked in underground coal mining as a roof bolter, continuous miner operator, and scoop operator for almost thirty years. He also noted that Claimant smoked cigarettes for over a thirty-five year period, with periods of abstinence. Claimant's subjective complaints were listed as exercise intolerance; dyspnea on exertion; daily cough, sometimes productive; wheezing; and chest tightness or pain. Dr. Tuteur opined that Claimant does not have pneumoconiosis or any coal mine dust-induced disease process. He wrote as follows:

> Based on the available data, there is no convincing information to indicate the presence of coal workers' pneumoconiosis or any other coal mine dust-induced disease process of sufficient severity and profusion to produce clinical symptoms, physical examination abnormalities, impairment of pulmonary function, or radiographic abnormalities. There is present chronic daily cough often productive of sputum. This fulfills the World Health Organization definition of chronic bronchitis. Though it is recognized that this symptom set can be due to the chronic inhalation of coal mine dust, the frequency with which such symptoms develop among persons who smoke cigarettes regularly is at least 20-fold greater. On this basis, with reasonable medical certainty, the chronic cough experienced by [Claimant] is due to the chronic inhalation of tobacco smoke which he continued as recently as January 17, 2003.

EX 3. Dr. Tuteur concluded that Claimant has only a "mild cigarette smoke-induced chronic bronchitis unassociated with significant and substantial impairment of pulmonary function." EX 3. He wrote as follows:

> Specifically there is no restrictive abnormality; there is no persistent impairment of gas exchange as manifested by arterial blood gas analysis. This condition is directly related to and caused by the chronic inhalation of tobacco smoke and is unassociated with and not caused by the chronic inhalation of coal mine dust.

Dr. Tuteur concluded that Claimant was totally disabled due only to his chronic low back syndrome. EX 3.

Claimant's medical records from King's Daughters Medical Center and Three Rivers Medical Center are also in evidence. CX 1, 2. A CT scan of the chest on February 19, 2003 showed mediastinal and hilar lymphadenopathy. CX 1. A PET scan was taken on February 25, 2003 and this showed "malignant lymphadenopathy" in the "hilar and mediastinal structures." It also showed "[a]bnormal examination with hypermetabolic uptake seen in the right lower lung anterior basal segment consistent with a malignancy." A mediastinoscopy was performed on March 26, 2003 and the results from the biopsy material showed evidence of sarcoidosis. A summary of Claimant's past medical history taken while he was in King's Daughter Hospital reveals the following: "diabetes; hypertension; disability due to lower back pain." CX 1.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201 (2005). In this case, Dr. Tweel diagnosed COPD and emphysema, both of which can be encompassed within the definition of legal pneumoconiosis. 20 C.F.R. § 718.201

(2005); *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only CODP and emphysema caused by coal dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003). Dr. Tweel made no such finding regarding the etiology of these conditions. In fact, Dr. Tweel specifically found smoker's bronchitis.

20 C.F.R. § 718.202(a) (2005) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in Sections 718.304 (irrebuttable presumption of total disability if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners who died on or before March 1, 1978), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. The biopsy of Claimant's right paratracheal lymph nodes showed no evidence of pneumoconiosis or even anthracotic pigment, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, Claimant filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. As this claim is governed by the law of the Sixth Circuit, Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at Section 202(a). *See Cornett v. Benham Coal Co.*, 227 F.3d 569, 575 (6th Cir. 2000); *Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314–315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151–152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148–1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319–320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Of the four available x-rays in this case, one has been read by one reviewer to be positive for pneumoconiosis, and the rest of the readings are either negative or silent as to the presence or absence of pneumoconiosis. For cases with conflicting x-ray evidence, the regulations specifically provide,

> … where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 C.F.R. § 718.202(a)(1) (2005); *Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-37 (1991). Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52.

Whether an x-ray interpretation which is **silent** as to pneumoconiosis should be interpreted as **negative** for pneumoconiosis, is an issue of fact for the ALJ to resolve. *Marra v. Consolidation Coal Co.*, 7 B.L.R. 1-216 (1984); *Sacolick v. Rushton Mining Co.*, 6 B.L.R. 1-930 (1984).

The May 11, 2001 chest x-ray was read as positive by Dr. Tweel, a B-reader. It was read as negative by Dr. Wiot, a dually-qualified radiologist. Dr. Sargent, a dually-qualified radiologist read the film for quality only and found it to be a "1." At best, this x-ray is in equipoise. As it is, I give more weight to Dr. Wiot's reading in light of the fact that he is a dually-qualified radiologist, and find that this x-ray is negative for pneumoconiosis.

The January 17, 2003 x-ray was read as negative by two dually-qualified physicians. There are no positive readings. I therefore find this x-ray to be negative for pneumoconiosis.

The March 26, 2003 x-ray was read by Dr. Yama who found "no acute pulmonary process," but otherwise made no reference to pneumoconiosis. Dr. Wiot found that this x-ray was unreadable. I find that this x-ray is not probative evidence of the presence or absence of pneumoconiosis.

Finally, the August 13, 2003 x-ray was found to be unreadable by Dr. Wiot. There are no other readings of this x-ray. I find that this x-ray is not probative evidence of the presence or absence of pneumoconiosis.

These constitute all of the x-ray interpretations in the record pertaining to Claimant's subsequent claim. I have found them to either negative or not probative of the issue of presence or absence of pneumoconiosis. Based on the foregoing, Claimant has not established the presence of pneumoconiosis by way of x-ray evidence.

I must next consider the medical opinions. Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the

judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (*en banc*). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co*., 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186-187 (6th Cir. 1995); *Justice v. Island Creek Coal Co*., 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). In this case, Claimant identified Dr. Sanchez as his current treating physician. However, there are no opinions from Dr. Sanchez to be considered.[5]

In this case there is only one physician who found evidence of pneumoconiosis, Dr. Tweel. It appears, however, that his opinion is based solely on his positive x-ray interpretation of May 11, 2001. This x-ray was subsequently found to be negative by a dually-qualified radiologist, and I found it to be negative. Opinions based solely on x-ray evidence which the ALJ has found insufficient to establish the existence of pneumoconiosis are entitled to little weight. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 514 (6th Cir. 2003). I am mindful that an administrative law judge must consider a medical report as a whole, *see Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988), and *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984), and may not discredit an opinion merely because it is based on an x-ray interpretation which is outweighed by the other x-ray interpretations of record. *See Worhach v. Director, OWCP*, 17 B.L.R. 1-105 (1993); *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986); *cf. Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111 (1989). Nevertheless, where x-ray evidence constitutes an apparent major part of the physician's documentation, his opinion may be entitled to diminished probative weight if that specific film has been reread as negative, and the administrative law judge makes a specific finding to that effect. *See generally Director, OWCP v. Rowe*, 710 F.2d 251, 255 n.6 (6th Cir. 1983). It appears that Dr. Tweel based his finding of "minimal" pneumoconiosis on the chest x-ray because it is on his chest x-ray report that he wrote "[m]inimal findings of coal workers' pneumoconiosis." DX 11.

The only other physician opinions to consider are those of Dr. Rosenberg and Dr. Tuteur. Neither physician diagnosed pneumoconiosis or any other coal mine dust-induced lung disease.

In assessing this evidence, I do not find that Dr. Tweel's opinion is without probative value. In resolving the conflict presented by the physicians of record, however, I find the opinions of Drs. Rosenberg and Tuteur merit greater probative weight. These credible and well-

[5]Dr. Sanchez's name appears on the February 27, 2003 pulmonary function and arterial blood gas studies contained in the King's Daughters Medical Center records. CX 1. There is no commentary or opinion from him otherwise.

reasoned medical opinions are convincing for purposes of establishing that Claimant does not have pneumoconiosis or any other respiratory or pulmonary impairment arising out of coal mine work. Dr. Tweel's opinion on the other hand appears to be based solely on an x-ray that has ultimately found to be negative, and as such his opinion is entitled to diminished weight on the specific issue of presence of disease. I find that the weight of the medical opinions of record fails to establish that Claimant pneumoconiosis as the Act requires for entitlement to benefits.

In sum, neither the x-ray evidence, nor the medical opinion evidence, weighed separately or together, is sufficient to establish the existence of pneumoconiosis. Nor has Claimant shown its presence by any other means, as the biopsy material and CT scans showed no evidence of pneumoconiosis. I find that Claimant has failed to meet his burden of showing that he has a pulmonary or respiratory disease attributable to his exposure to coal dust. Thus he cannot show that he is entitled to benefits under the Act.

Total Pulmonary or Respiratory Disability

Assuming a*rguendo* that Claimant had established that he has pneumoconiosis, his claim would still fail because he has not established that he is totally disabled by a pulmonary or respiratory impairment.

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 C.F.R. § 718.304 (2005), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 C.F.R. § 718.204(b) and (c) (2005). The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 C.F.R. § 718.204(b) and (d) (2005). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 C.F.R. § 718.204(d) (2005); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that Claimant suffers from complicated pneumoconiosis or cor pulmonale. Thus I will consider pulmonary function studies, blood gas studies, and medical opinions. In the absence of contrary probative evidence, evidence from any of these categories may establish disability. If there is contrary evidence, however, I must weigh all the evidence in reaching a determination whether disability has been established. 20 C.F.R. § 718.204(b)(2) (2005); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986).

In the instant case, none of the pulmonary function or blood gas studies produced values indicative of total disability. Therefore, total disability cannot be established pursuant to 20 C.F.R. § 718.204(b)(i) or (ii) (2005). Furthermore, of the physicians who examined Claimant or reviewed his records, none found that he had any pulmonary or respiratory disability, let alone a total disability that prevents him from performing his usual coal mine employment.[6] When the

[6]Dr. Tweel's opinion actually provided no opinion regarding presence or degree of a pulmonary disability or impairment.

physician opinions are considered in conjunction with the results of the objective tests, I find that Claimant has failed to establish that he is totally disabled by a pulmonary or respiratory impairment.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Claimant is unable to establish any element of entitlement. Accordingly, Claimant is unable to establish that one of the applicable conditions of entitlement has changed since the denial of his previous claim for purposes of his subsequent claim. For this reason, Claimant is not entitled to benefits under the Act.

ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which Claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim for benefits filed by Clarence Harless on February 27, 2001 is hereby DENIED.

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ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).